Public Employees Benefits Board (PEBB)

2004 Medical and Dental Coverage

- n List all eligible family members and indicate their enrollment status on this form.
- n Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.

Are you making changes to an existing account?	If yes, what type of changes:		- /	D.Madiantalan			
Yes No	☐ Name ☐ Adding family mer	☐ Addres mber ☐ Re-en		Medical planWaiving coverage	☐ Dental plan☐ Termination		
3.55 3.15	Adding family men	ilbei 🔲 ne-eii	TOITHETIL	waiving coverage	remination		
Section 1: Subscriber	nformation						
Social security number	Last name		First nam	ne	Middle initial Sex		
					□ M □ F		
Address				Apt./un	t number		
City		State	ZIP C	ode (County of residence		
			L				
Date of birth (mm/dd/yyyy)	Work phone number (including are	ea code)	Home	phone number (including	g area code)		
The medical plans marked with a	n asterisk* in Section 4 assign a p	hysician or clinic c	ode to the	eir Physician	name or clinic code		
providers and require you to choose	se a primary care provider. To fine						
or go to the Provider Directory	on our Web site.						
Medical Coverage	☐ Waive: date effective		If waiving, see				
Dental Coverage ☐ Enr	oll (Dental may not be waive	ed)			ly not waive medical coverage and cover family members.		
Dental Coverage	(Bernai may not be waive				inity members.		
-	ame-Sex Domestic Part		tatus, eve	en if you do not want cov	erage for them		
(see Section 6); they cannot be	enrolled in any other PEBB covera	ge.		•			
Relationship to Subscriber		☐ Snouse: date	of marria	ige			
If adding a spouse or partner, ple	ase attach a completed						
Declaration of Marriage/Same-Se		☐ Same-sex do	mestic pa	rtner: date criteria met_			
Social security number	Last name		First nam	ne N	Middle initial Sex ☐ M ☐ F		
Address (if different from subscri	per)	City		Stat			
Date of birth (mm/dd/yyyy)	Dhysisian name or slinis code (antast plan for as	,da\				
Date of birth (mm/dd/yyyy)	Physician name or clinic code (contact plan for co	oue)				
Medical Coverage	oll Waive: date effective						
_			If waiving, see Section 6.				
Dental Coverage	DII Waive: date effective						
Terminate Medical & Dental Co	verage Divorce/Dissolu	ution of partnership	: date of	event			
	Please provide his	s/her new address					
	·						
	☐ Death: date of	event					
	Other:			Date effective			
<u> </u>							



Agency name	Agency/subagency	Ins. effective date	Hire date		

Disabled? Disabled? Sex M P	Section 3: Family Member Information (such as List all eligible family members and indicate their enrollment status coverage. Use additional forms for more members.			ers cannot be eni	rolled in a	iny othe	er PEBI	3	
Social security number	A Relationship to subscriber					Sex	□М	□F	
Address (if different from subscriber) Medical Coverage Enroll Walve: date effective Reason R	Social security number				your plai	n for co	de)		
Medical Coverage Enroll Waive: date effective Dat	Last name First name		Middle initia Date of birth (mm/dd/yy					ууу)	
Dental Coverage	Address (if different from subscriber)	City			State ZIP Code				
Relationship to subscriber	Medical Coverage ☐ Enroll ☐ Waive: date effective								
Check only if age 20 or older.) Sex M F Social security number Physician name or clinic code (contact your plan for code)			1						
Social security number	B Relationship to subscriber					Sex	□М	□F	
Address (if different from subscriber) Medical Coverage Enroll Walve: date effective Reason Date effective Date effective Reason Date effective Date effective Date effective Reason Date effective Date effective	Social security number				your plai	n for co	de)		
Medical Coverage Enroll Waive: date effective Reason Date effective Date effe	Last name First name			Middle initia	Date of	birth (m	ım/dd/y	ууу)	
Dental Coverage	Address (if different from subscriber)	City	City		State	ZIP Code)	
C Relationship to subscriber	Medical Coverage ☐ Enroll ☐ Waive: date effective		☐ Terminate						
Disabled? Student? Sex M F			1						
C(Check only if age 20 or older.) Set Mildle initia Physician name or clinic code (contact your plan for code) Physician name or clinic code (contact your plan for code) Middle initia Date of birth (mm/dd/yyyy)	Deletionship to subscriber								
Last name First name Middle initial Date of birth (mm/dd/yyyy) Address (if different from subscriber) City State ZIP Code Medical Coverage Enroll Waive: date effective Reason Date effective Date of fective		[(C	heck only if age 2	20 or older.)	vour nlai		_	U F	
Address (if different from subscriber) Medical Coverage Enroll Waive: date effective Reason Date effective Dat	·	1 1198	siciali fiame of ci	<u> </u>				vvv)	
Medical Coverage		C:t-							
Dental Coverage	,		T		State	21	P Code	.	
Section 4: Medical Plan Selection (Check only one.)			_						
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Community Health Plan of Washington*	ii waiving, see decitori d.		Bate offeetive						
Group Health Coperative* Group Health Coptions, Inc. Uniform Medical Plan Preferred Provider Organization Managed Care Plans DeltaCare (Group #3100) Managed Care Plans DeltaCare (Group #3100) Managed Care Plans DeltaCare (Group #3100) Dentist name or clinic code of pour selected provider. Managed Care Plans DeltaCare (Group #3100) Dentist name or clinic code (must receive services from any provider) Regence BlueShield Columbia Dental Plan Dental Plan and DeltaCare. Regence BlueShield Columbia Dental Plan Clinic location Clinic location (must receive services from Williamette Dental Group provider) Gection 6: Signature (Required) I declare that my family members and I are eligible for the coverage requested. I authorize my employer to deduct from my earnings any premium I am required to pay for the coverage I have selected. I understand that I may be subject to dismissal and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority to be ineligible for coverage. I declare that I or any family members who have chosen to waive medical/dental coverage, as indicated above, currently have other continuous, similar medical/dental insurance. I understand that proof of continuous, similar medical/dental coverage will be required to re-enroll family members in a PEBB plan outside of an open enrollment period. Application for re-enrollment must be made within 31 days of losing other coverage. This form supercedes all forms and submissions I have previously made for PEBB coverage. Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.g	· · ·	.)							
Group Health Options, Inc. Group Health Options, Inc. Haiser Foundation Health Plan of the Northwest Group Health Options, Inc. Group Health Options Health Plan of the Northwest									
Raiser Foundation Health Plan of the Northwest Provider Organization Interpretable Int			care provider.			Contact the plan for code			
Section 5: Dental Plan Selection (Check only one.) Preferred Provider Organization Uniform Dental Plan (Group #3000) (may receive services from any provider) Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare. Regence BlueShield Columbia Dental Plan Clinic location (must receive services from Willamette Dental Group provider) Section 6: Signature (Required) I declare that my family members and I are eligible for the coverage requested. I authorize my employer to deduct from my earnings any premium I am required to pay for the coverage I have selected. I understand that I may be subject to dismissal and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority to be ineligible for coverage. I declare that I or any family members who have chosen to waive medical/dental coverage, as indicated above, currently have other continuous, similar medical/dental insurance. I understand that proof of continuous, similar medical/dental coverage will be required to re-enroll family members in a PEBB plan outside of an open enrollment period. Application for re-enrollment must be made within 31 days of losing other coverage. This form supercedes all forms and submissions I have previously made for PEBB coverage. Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.			9						
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